Avēsis INCORPORATED

VISION BENEFITS CLAIM FORM

PLEASE BE AS COMPLETE AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS CLAIM FORM. ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS.

Member: *It is not necessary to complete Part B and Part C. Please attach an itemized receipt from the provider of care.*

PART A. -- TO BE COMPLETED BY CARDHOLDER

1. PATIENT'S NAME *(Last, First, Middle)*	2. CARDHOLDER'S GROUP #	3. CARDHOLDER"S ID #

4. PATIENT'S DATE OF BIRTH	5. PATIENTS SEX	6. RELATIONSHIP TO CARDHOLDER	7. CARDHOLDER'S NAME *(Last, First, Middle)*
/ /	☐ M ☐ F	☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	, ,

8. CARDHOLDER'S ADDRESS (No., Street, City, State and Zip Code)	9. HOME NUMBER ( ) -	WORK NUMBER ( ) -

10. NAME OF INSURANCE CARRIER	11. NAME OF EMPLOYER	12. CARDHOLDER'S STATUS	13. CARDHOLDER'S DATE OF BIRTH
		☐ Active ☐ Retired ☐ Hourly ☐ Salaried	

14. PATIENT IS COVERED FOR VISION CARE BY ANOTHER PLAN ☐ YES ☐ NO IF YES, PLEASE COMPLETE BOXES 15 THROUGH 19	15. NAME AND ADDRESS OF THE OTHER CARRIER

16. POLICYHOLDER'S NAME	17. RELATIONSHIP TO CARDHOLDER	18. POLICYHOLDER'S DATE OF BIRTH	19. POLICYHOLDER'S S.S.# /GROUP #
	☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	/ /	

20. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO AVESIS INCORPORATED ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION PROVIDED BY ME IN SUPPORT OF THIS CLAIM IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE ABOVE NAMED PATIENT.

PAYMENT FOR ANY BENEFITS SHOULD BE MADE TO: ☐ SUBSCRIBER ☐ DOCTOR ☐ DISPENSER

SIGNATURE OF CARDHOLDER _____ (DATE SIGNED) _____

PART B. -- TO BE COMPLETED BY DOCTOR

1. DOCTOR'S NAME *(Last, First, Middle)*	2. TITLE ☐ D.O. ☐ M.D. ☐ O.D.	3. Assignment cannot be made without tax I.D. number. DOCTOR'S TAX I.D. #
4. DOCTOR'S ADDRESS (No., Street, City, State and Zip Code)	5. Phone ( )	

6. EXAMINATION DATE PLEASE ENTER EXAMINATION CHARGE BELOW IN FEE COLUMN BELOW (BLOCK 19)	7. DIAGNOSIS OR NATURE OF OFFICE VISIT	8. HAS CATARACT SURGERY BEEN PERFORMED? ☐ YES ☐ NO

9. CAN VISUAL ACCUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTIONAL EYEGLASSESD? ☐ YES ☐ NO	10. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? ☐ YES ☐ NO	11. WERE EYEGLASSES PRESCRIBED? ☐ YES ☐ NO WERE CONTACTS PRESCRIBED? ☐ YES ☐ NO

12. DOCTOR'S PRESCRIPTION

	Sphere	Cylinder	Axis	Prism
R				
L				
READING ADD				

13. DID YOU PERFORM REFRACTION? ☐ YES ☐ NO

14. I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON

DOCTOR'S SIGNATURE

PART C. -- TO BE COMPLETED BY DOCTOR/DISPENSER

CHECK APPROPRIATE BOX

													15. AMOUNT
FRAME	SIZE & MODEL				MFG.		ZYL	METAL	RIMLESS	COMBO			EXAMINATION CHARGE
LENSES	# OF LENSES	GLASS	PLASTIC		SV	BIF	TRI	PAL	SAFETY	OTHER			FRAME CHARGE
LENS OPTIONS	OS	TINT	GRAD	DBL GRAD	COAT	UV 400	FACET	PHOTO CHROMIC	OTHER				LENS CHARGE
CONTACT LENS	# OF LENSES	HCL	SCL	HGP	DISPOSABLE	SPH	BIF	TORIC	EW	TINT	REPLACEMENT	OTHER	OPTIONS CHARGE
													CONTACT LENSES

DATE ORDERED	DATE DISPENSED	OTHER SERVICES	OTHER SERVICES

DISPENSING OFFICE	PHONE ( )	SUBTOTAL

ADDRESS STREET	CITY	STATE	ZIP	SALES TAX (If Applicable)

I hereby certify that I have performed the services as indicated hereon	Assignment cannot be made without tax I.D. number Dispenser's Tax I.D. number_____	TOTAL CHARGES
		AMOUNT PAID BY PATIENT

DISPENSER'S SIGNATURE	DATE	FOR AVESIS USE ONLY CC

PLEASE SUBMIT THIS CLAIM TO Avesis Incorporated, CLAIMS DEPARTMENT, P.O. BOX 7777, PHOENIX, AZ 85011-7777

SEE REVERSE SIDE FOR INSTRUCTIONS

Avēsis
INCORPORATED

A. Please Print or Type the cardholder portion of this form, in full, to assure prompt reimbursement. Both the cardholder and the dependent (unless a minor) should sign and date this form.

B. If two different providers are involved in providing the examination and the frame, lenses, or contact lenses, then each provider should complete the appropriate section of the form.

C. After the form is completed it should be mailed to the address shown below:

Avesis Incorporated
Vision Claim Department
PO Box 7777
Phoenix, AZ 85011-7777

D. For more information on completing this claim form call Avesis at 1-800-828-9341.

ABREVEATIONS

Frame

MFG……	Manufacturer
ZYL……	Plastic
COMBO……..…….….	Combonation (zyl/metal)

Lenses

SV……..	Single Vision
BIF……..	Bifocal
TRI……..	Trifocal
PAL……	Progressive add lenses

Lens Options

OS……	Oversize
GRAD……..	Gradient

Contact Lenses

HCL……	Hard contact lenses
SCL……	Soft contact lenses
HGP……	Hard gas permeable
SPH……	Spherical
BIF……..	Bifocal